Nursing Home Conditions in the Second Congressional District of Mississippi: Many Homes Fail to Meet Federal Standards for Adequate Care

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Prepared for Rep. Bennie G. Thompson

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

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EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health standards.

To address these growing concerns, Rep. Bennie G. Thompson asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in his district, the Second Congressional District of Mississippi. This district is located in the western portion of the state and includes the cities of Greenville, Vicksburg, and a portion of Jackson. There are 43 nursing homes in the Second Congressional District that accept residents covered by Medicaid or Medicare. These homes serve over 3,000 residents. This is the first congressional report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many of the nursing homes in the Second Congressional District. Over 90% of the nursing homes in the district violated federal health standards during recent state inspections. Moreover, almost one-third of the nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes and to investigate nursing home complaints. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents.

This report is based on an analysis of these state inspections. It examines the most recent annual inspections of nursing homes in the Second Congressional District, which were conducted between August 2001 and October 2002. In addition, the report examines the results of any complaint investigations conducted during this time period.

Because this report is based on recent state inspections, the results are representative of current nursing home conditions in the region as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in the Second Congressional District, not an analysis of current conditions in any

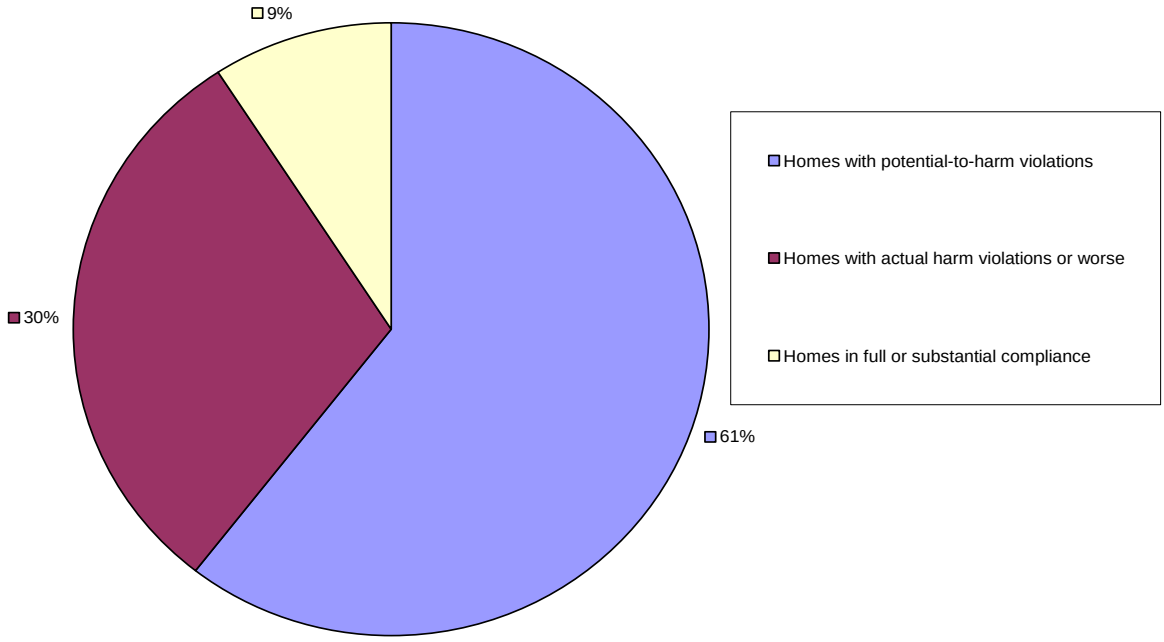
specific home. At any individual nursing home, conditions could be better – or worse – today than when the most recent inspection was conducted.

B. Findings

The vast majority of the nursing homes in the Second Congressional District violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health standards if no violations are detected during the annual inspection or a complaint investigation. They consider a nursing home to be in "substantial compliance" with federal standards if the violations at the facility do not have the potential to cause more than minimal harm. Of the 43 nursing homes in the Second Congressional District, only four facilities (9%) were found to be in full or substantial compliance with the federal standards. In contrast, 39 nursing homes (91%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 39 nursing homes had seven violations of federal quality of care requirements.

Many nursing homes in the Second Congressional District had violations that caused actual harm to residents. Of the 43 nursing homes in Rep. Thompson's district, 13 facilities – almost one-third of all facilities – had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). The 13 nursing homes with actual harm violations or worse serve 1,236 residents and are estimated to receive over $15 million each year in federal and state funds.

Table 1. Compliance Status of Nursing Homes in Mississippi Second Congressional District



The state inspection reports documented serious care problems. Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations are actually trivial in nature. To assess these claims, this report examined in detail the annual inspection reports from 15 nursing homes in Rep. Thompson's district cited for multiple violations. The inspection reports for these homes documented that the actual harm violations cited by state inspectors involved serious neglect and mistreatment of residents. Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that significant deficiencies can exist at nursing homes cited for potential-to-harm violations.

Examples of the violations documented by inspectors in the Second Congressional District of Mississippi included the following:

- Facilities that failed to provide adequate medical care, such as allowing wounds to become infested with maggots and worms. These violations may have been a factor in the deaths of three residents;

- Facilities that failed to protect residents from falls and accidents that resulted in serious injuries, including the death of one resident;

- Facilities that failed to protect residents from sexual abuse by staff and other residents; and

- Facilities that failed to prevent or properly treat pressure sores.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns – and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 35 million Americans, 12.4% of the population.[2] By 2030, the number of

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[1]Health Care Financing Administration, *Medicare Enrollment Trends, 1966 - 1999* (available at http://www.hcfa.gov/stats/enrltrnd.htm).

[2]U.S. Census Bureau, *Profiles of General Demographic Characteristics: 2000 Census of Population and Housing, United States* (May 2001).

Americans aged 65 and older is expected to increase to 70.3 million, 20% of the population.[3]

This aging population will increase demands for long-term care. In 2000, there were 1.5 million people living in more than 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives. Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years.[5] By 2050, the total number of nursing home residents is expected to quadruple from the current 1.5 million to 6.6 million.[6]

Most nursing homes are run by private, for-profit companies. Of the 17,023 nursing homes in the United States in 2000, over 11,000 (65%) were operated by for-profit companies.[7] During the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up smaller chains and independent homes. As of December 2000, the six largest nursing home chains in the United States operated 2,163 facilities with almost 260,000 beds.[8]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2002, it is projected that federal, state, and local governments will spend $65.9 billion on nursing home care, of which $51.5 billion will come from Medicaid payments ($32.8 billion from the federal government and $18.7 billion from state governments) and $12 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $37.8 billion ($26 billion from residents and their families, $7.7 billion

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[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045* (Dec. 1999).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, vii (2001).

[5]HCFA Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]*Facts and Trends, supra* note 4, at vii.

[7]*Id.* at viii.

[8]Aventis Pharmaceuticals, *Managed Care Digest Series 2001* (available at http://www.managedcaredigest.com/edigests/is2001/is2001.shtml).

from private insurance policies, and $4.1 billion from other private funds).[9] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a facility's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[10] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This law requires nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[11]

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises, caused by pressure or friction that can become infected. They also establish other health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and antipsychotic drugs, have been reduced.[12] But health violations appear to be widespread. In a series of 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that

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[9]All cost projections come from: HCFA, *Nursing Home Care Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980 - 2011* (available at http://www.hcfa.gov/stats/nhe%2Dproj/proj2001/tables/t14.htm).

[10]Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: "[I]ndividuals who are admitted receive very inadequate – sometimes shockingly deficient – care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

[11]42 U.S.C. §1396r(b)(2).

[12]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998).

"more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[13] that these incidents of actual harm "represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death";[14] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[15]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[16] In March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to the quality of resident care.[17] And in March 2002, HHS released a study that found that over 90% of nursing homes have staffing levels that are too low to provide adequate care.[18]

In light of the growing concern about nursing home conditions, Rep. Bennie G. Thompson asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health violations in nursing homes in his congressional district. Rep. Thompson represents the Second Congressional District of Mississippi, which is located in the western portion of the state and includes the cities of Greenville, Vicksburg, and a portion of Jackson. This is the first congressional report to comprehensively investigate nursing home conditions in the Second Congressional District.

II. METHODOLOGY

To assess the conditions in nursing homes in Rep. Thompson's congressional district, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) state inspection reports from 15 nursing homes in Rep. Thompson's district.

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[13]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (Mar. 1999).

[14]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[15]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (Mar. 1999).

[16]Testimony of Charlene Harrington before the Senate Special Committee on Aging (July 28, 1998).

[17]HHS Office of Inspector General, *Nursing Home Survey and Certification: Deficiency Trends* (Mar. 1999).

[18]HHS Report to Congress, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report*, 1-6 (Winter 2001).

A. Determination of Compliance Status

Data on the compliance status of nursing homes in the Second Congressional District comes from the OSCAR database and the complaint database. These databases are compiled by the Centers for Medicare and Medicaid Services (CMS), a division of HHS.[19] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to CMS, and compiled in the OSCAR and complaint databases.[20]
The OSCAR and complaint databases use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: CMS's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	Scope of Deficiency		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

[19]Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA).

[20]In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the home accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, CMS maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

To assess the compliance status of nursing homes in the Second Congressional District, this report analyzed the OSCAR database to determine the results of the most recent annual inspections of each nursing home in the region. These inspections were conducted between August 2001 and October 2002. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR and complaint databases, this report analyzed a sample of the actual inspection reports prepared by state inspectors of nursing homes in the Second Congressional District. These inspection reports, prepared on a CMS form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

The Special Investigations Division selected for review the inspection reports from 15 nursing homes that were cited for multiple, serious violations. For each of these facilities, the most recent state inspection report was obtained from the Mississippi State Department of Health. For several of these nursing homes, the Special Investigations Division also obtained reports of other annual inspections and complaint investigations conducted by the Mississippi State Department of Health over the past two years. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

The results presented in this report are representative of current conditions in nursing homes in Rep. Thompson's district. In the case of any individual home, however, current conditions may differ from those documented in the most recent inspection report, especially if the report is more than a few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a "yo-yo pattern" of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.[21]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in the Second Congressional District. It is not intended to be – and should not be interpreted as – an analysis of current conditions in any individual nursing home.

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[21] GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 12-14.

The report also should not be used to compare violation rates in nursing homes in Rep. Thompson's district with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect violations. According to GAO, "[c]onsiderable inter-state variation still exists in the citation of serious deficiencies."[22]

III. NURSING HOME CONDITIONS IN THE SECOND CONGRESSIONAL DISTRICT

There are 43 nursing homes in the Second Congressional District that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 3,525 beds that were occupied by 3,092 residents during the most recent round of annual inspections. The majority of these residents, 2,641, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 240 residents. Seventy-two percent of the 43 nursing homes in Rep. Thompson's district are private, for-profit nursing homes.

The results of this investigation indicate that the conditions in these nursing homes often fall substantially below federal standards. Many residents are not receiving the care that their families expect and that federal law requires.

A. Prevalence of Violations

Only four of the nursing homes in the Second Congressional District were found by the state inspectors to be in full or substantial compliance with federal health requirements. The rest of the nursing homes – 39 out of 43 – had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Thirteen facilities had violations that caused actual harm to residents or had the potential to cause death or serious injury. Table 2 summarizes these results.

Table 2: Nursing Homes in the Second Congressional District Had Numerous Violations that Placed Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	3	7%	192
Substantial Compliance (Risk of Minimal Harm)	1	2%	35
Potential for More than Minimal Harm	26	60%	1,629
Actual Harm to Residents	9	21%	796
Actual or Potential Death/Serious Injury	4	9%	440

[22] GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (Sept. 2000).

Many nursing homes had multiple violations. State inspectors found a total of 275 violations in facilities that were not in complete or substantial compliance with federal requirements, an average of seven violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. These are homes with violations ranked at the G-level or above. As shown in Table 2, 13 nursing homes in Rep. Thompson's district – 30% of all facilities – had violations that fell into this category, including four nursing homes cited for violations that had the potential to cause death or serious injury. These 13 nursing homes serve 1,236 residents and are estimated to receive over $15 million in federal and state funds each year. Moreover, six nursing homes had two or more actual harm violations.

C. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part on the data reported to CMS in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[23] One problem, according to GAO, is that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[24] A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health standards.[25] Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

Representatives of the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[26] AHCA also claims that deficiencies cited by inspectors are often "technical

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[23] GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 13, at 30.

[24] GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

[25] *Nursing Homes: Sustained Efforts Are Essential*, *supra* note 22, at 43.

[26] Statement of Linda Keegan, Vice President, AHCA, regarding Senate Select Committee on Aging Forum: "Consumers Assess the Nursing Home Initiatives" (Sept. 23, 1999).

violations posing no jeopardy to residents" and that the current inspection system "has all the trademarks of a bureaucratic government program out of control."[27] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[28]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including "pressure sores, broken bones, severe weight loss, burns, and death."[29] GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe than violations cited in previous or subsequent annual inspections.[30]

This report undertook a similar analysis at the local level. To assess the severity of violations at nursing homes in the Second Congressional District, the Special Investigations Division examined the annual inspection reports for 15 nursing homes in the district with multiple violations. These inspection reports showed that the actual harm violations cited by state inspectors involved numerous examples of serious neglect and mistreatment of residents. The violations documented in the reports included improper medical care, preventable falls and accidents, sexual abuse, and inadequate care for pressure sores. In several instances, these violations led to the death or serious injury of residents.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations that caused actual harm (G-level and above). To the contrary, many of the violations classified as having a "potential for more than minimal harm" (violations at the D, E, or F levels) involved conditions and mistreatment that would be regarded by families of residents as unacceptable. The

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[27] AHCA Press Release, *AHCA Responds to Release of General Accounting Office Study on Enforcement* (March 18, 1999).

[28] Letter from Sen. Charles E. Grassley to William Scanlon (GAO), 1 (May 27, 1999).

[29] GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 14, at 2.

[30] *Id.* at 6. A subsequent GAO study in August 1999 examined several examples provided by AHCA of serious deficiencies cited by state inspectors that AHCA asserted were of questionable merit. For those deficiencies that it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against these homes were merited. The GAO report stated: "In our analysis of the cases that AHCA selected as 'symptomatic of a regulatory system run amok,' we did not find evidence of inappropriate regulatory actions." Letter from Kathryn G. Allen (GAO) to Sen. Charles E. Grassley, 2 (Aug. 13, 1999).

severity of these violations indicates that serious deficiencies can exist even at nursing homes that are not cited for actual harm violations.

The following discussion summarizes some examples of the violations documented in the inspection reports.

A. Failure to Provide Proper Medical Care

Several nursing homes in Rep. Thompson's district were cited for improper or inadequate medical care, which may have been a factor in the deaths of three residents. In one serious incident, state inspectors cited a facility for failing to prevent a "maggot infestation" in a resident's gangrenous toes. The resident was diagnosed with peripheral vascular disease. After the facility failed to provide physician-ordered anti-clotting medication and perform necessary tests, a nurse noted that the resident's toes had dead tissue and "visible objects were noted in [the] wound." The resident was sent to the hospital with "gangrene of the left lower extremity and 'infestation' of the wound with maggots." The resident's legs had to be amputated above the knee a few days later and she died a week after admission to the hospital.[31]

A similar violation occurred at a second facility, where a resident's family told the facility that the resident's wound had an "unclean dressing and nasty things were in the wound." Upon investigation, the staff observed "a small white worm" crawling out of the resident's leg. A month earlier, the wound had only been an abrasion on the resident's leg, yet it developed into an open sore with watery drainage.[32]

In other serious cases:

- A facility took four days to obtain a chest x-ray ordered by a physician for a resident with asthma, continuous aspiration, chronic obstructive pulmonary disease, and a history of aspiration pneumonia. When the facility finally sent the resident for chest x-rays, the resident had to be admitted to the hospital and died nine days later of aspiration pneumonia. [33]

- A facility failed to perform several glucose checks for a diabetic resident within a two-week period. The resident was subsequently transferred to a hospital and died two weeks later in part from "[d]ehydration due to an uncontrollable

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[31]CMS Form 2567 for Nursing Home in Jackson (June 4, 2002) (G-level violation).

[32]CMS Form 2567 for Nursing Home in Clarksdale (Nov. 7, 2001) (G-level violation).

[33]CMS Form 2567 for Nursing Home in Clarksdale (Jan. 30, 2001) (D-level violation).

electrolyte imbalance," which could have been related to inadequately-controlled diabetes.[34]

- A facility placed a resident in immediate jeopardy after the staff failed to unclamp the catheter that drained the resident's bladder upon the resident's return from the hospital. The resident was found with a distended bladder after the catheter had been clamped for 19 hours, preventing the resident from urinating.[35]

Several nursing homes were cited for their failure to properly administer medications, including giving residents twice the prescribed dosage, providing medications at the wrong time, giving residents the wrong medication, and completely failing to give residents their medications.[36] In the most egregious case, a resident suffered a severe allergic reaction when a facility gave the resident six doses of a sulfur drug, even though the resident's medical record noted an allergy to sulfur. After the staff had given the resident the drug for three days, they noticed that the resident had "reddened skin areas and sloughing off of skin." The resident was sent to an emergency room and then to a burn center because of the high risk of infection. Seventy-four percent of the resident's body area was involved in the allergic reaction, which was identified as toxic epidermal necrolysis, a condition that involves multiple large blisters that coalesce, followed by sloughing off of all or most of the skin and mucous membranes.[37]

B. Failure to Prevent Falls and Accidents

A number of nursing homes in the Second Congressional District were cited for not taking adequate precautions to prevent falls and accidents.[38] In the most serious case, a

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[34]CMS Form 2567 for Nursing Home in Grenada (May 18, 2001) (D-level violation).

[35]CMS Form 2567 for Nursing Home in Yazoo City (Apr. 19, 2002) (J-level violation).

[36]CMS Form 2567 for Nursing Home in Jackson (Aug. 23, 2002) (E-level violation); CMS Form 2567 for Nursing Home in Jackson (June 13, 2002) (E-level violation); CMS Form 2567 for Nursing Home in Yazoo City (Apr. 19, 2002) (E-level and J-level violations); CMS Form 2567 for Nursing Home in Vicksburg (July 13, 2001) (E-level violation); CMS Form 2567 for Nursing Home in Jackson (June 21, 2001) (K-level violation).

[37]CMS Form 2567 for Nursing Home in Grenada (Oct. 5, 2001) (I-level violation).

[38]CMS Form 2567 for Nursing Home in Indianola (Nov. 29, 2001) (D-level violation); CMS Form 2567 for Nursing Home in Grenada (Nov. 2, 2001) (D-level violation); CMS Form 2567 for Nursing Home in Clarksdale (Nov. 1, 2001) (D-level and G-level violations); CMS Form 2567 for Nursing Home in Yazoo City (Oct. 30, 2001) (G-level violation); CMS Form 2567 for Nursing Home in Clarksdale (Sept. 13, 2001) (G-level violation).

resident died after falling out of her wheelchair because the staff failed to secure the resident with a required chest harness. State inspectors discovered that for the previous year there had been no formal staff training on the use of the harness, even though the resident had a physician order for the harness. The resident was found on the floor with her head in a garbage can lined with a plastic bag and died shortly thereafter.[39]

A resident at a different facility suffered a fractured hip and leg when a nurse aide transferred the resident alone, even though the resident's record showed that the resident needed the assistance of two people for transfers. The resident fell to the floor while the nurse aide was putting a mechanical lift in place. When state inspectors reviewed records for the previous month, they discovered that the resident had been transferred by only one aide for 28 of 28 days on one shift, and 26 of 28 days on another shift.[40]

In a similar incident, a nurse aide at another facility broke two ribs of a resident when the nurse aide manually lifted the resident out of bed even though the resident's care plan stated that she needed "extensive assistance" and a mechanical lift when necessary.[41]

State inspectors also found that several nursing homes were not adequately supervising residents, allowing them to wander away from the facilities.[42] For example:

- One facility failed to adequately supervise a resident with a history of wandering, allowing the resident to leave the facility and walk down a well-traveled city street. Passersby saw the resident slip and fall, prompting a witness to call an ambulance.[43]

- Another nursing home, located on a busy five-lane highway, was unaware that a resident had wandered away until the facility was notified by the local police. The resident left the facility early in the morning and walked seven blocks to the police station. The resident had a bracelet that triggered an alarm if the resident attempted to exit the building. Although door alarms sounded, the staff merely

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[39]CMS Form 2567 for Nursing Home in Belzoni (Sept. 12, 2001) (J-level violation) (this home has subsequently changed ownership).

[40]CMS Form 2567 for Nursing Home in Grenada (Mar. 14, 2001) (G-level violation).

[41]CMS Form 2567 for Nursing Home in Ruleville (Jan. 24, 2002) (G-level violation).

[42]CMS Form 2567 for Nursing Home in Ruleville (Feb. 28, 2001) (J-level violation); CMS Form 2567 for Nursing Home in Grenada (Jan. 10, 2001) (D-level violation).

[43]CMS Form 2567 for Nursing Home in Vicksburg (Oct. 19, 2001) (G-level violation).

looked outside before turning off the alarms and failed to check that all residents with bracelets were in the facility.[44]

- At a third facility, a resident with a history of wandering crossed a well-traveled state highway and was found on the porch of a home near the facility. Even though a door alarm had sounded, the staff failed to conduct a proper search outside the building.[45]

C. Failure to Protect Residents from Sexual Abuse

State inspectors found several incidents of sexual abuse of residents. At one facility, a male staff member was caught standing near the bed of a 96-year-old "vulnerable" female resident, with an erection and "adjusting his penis." Another female resident in the facility told inspectors that she awoke one morning and found the same male staff member standing beside her bed "with his hand in his pants fondling himself." The male staff member had previously been fired after physically threatening his supervisor, at which time he had to be escorted off the facility premises by police. Despite this history of abusive behavior, the staff member was rehired a few months later. The facility also failed to learn that the staff member had been both convicted of a drug offense and placed on five years' probation while working at the facility.[46]

A second facility failed to protect a cognitively impaired female resident from sexual abuse by a male resident. The male resident was found in the activity/dining room of the facility, standing in front of the female resident, who was sitting on a sofa. The male resident had his penis in the female resident's mouth and was "holding on to [her] shirt in [an] attempt to move [her] body back an[d] forth with the thrusting movements of [his] body." When a nurse asked, "What are you doing?" the male resident responded by immediately removing his penis from the female resident's mouth, placing his penis in his pants, and turning and walking out of the room. At the time, there were three other residents in the room who were moderately cognitively impaired. The incident occurred even though the facility knew that the male resident had a history of inappropriate sexual behavior, including: leaving the facility twice a week with his brother, who the resident said helped him "buy sex"; openly masturbating; and inappropriately touching other females.[47]

D. Failure to Prevent or Properly Treat Pressure Sores

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[44]CMS Form 2567 for Nursing Home in Indianola (June 14, 2001) (J-level violation).

[45]CMS Form 2567 for Nursing Home in Ruleville (June 26, 2001) (J-level violation).

[46]CMS Form 2567 for Nursing Home in Vicksburg (July 31, 2001) (J-level violation).

[47]CMS Form 2567 for Nursing Home in Vicksburg (Mar. 28, 2002) (J-level violation).

State inspectors also cited facilities in the Second Congressional District for failing to prevent or properly treat pressure sores.[48] At one nursing home, a resident had a pressure sore that was "infected, odorous, with purulent drainage," from which tissue had to be surgically removed. The resident also had a second serious sore with "light green slough" and "undermining."[49]

Another facility failed to properly care for a resident with a pressure sore on her back. Even though the facility knew that the "resident had a history of this area opening up on occasions if [she] is not turned properly," inspectors repeatedly observed the resident positioned on her back. The sore worsened over two weeks, resulting in "increased depth" and "moderate drainage."[50] The same facility failed to address a resident's nutritional needs upon the resident's return from a hospital stay. The resident developed two pressure sores within three weeks of returning to the facility.[51]

At a third facility, a resident suffered a significant weight loss in six months, which can lead to pressure sores, yet the facility repeatedly failed to provide a physician-ordered nutritional supplement. The resident developed a pressure sore less than a month after the physician's order for the nutritional supplement. The same facility failed to provide another resident with sufficient calories and protein. The resident, who already had one pressure sore, developed three new sores in six weeks.[52]

E. Other Violations

State inspectors found that one facility placed residents at risk of immediate jeopardy by failing to keep its water within an appropriate temperature range to prevent burns. Inspectors found that water temperatures in some of the residents' rooms exceeded 140 degrees and went as high as 155 degrees, temperatures that can cause serious burns within seconds of exposure. Residents in the affected area were all ambulatory, and half the residents were cognitively impaired.[53]

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[48]CMS Form 2567 for Nursing Home in Yazoo City (Apr. 19, 2002) (G-level and J-level violations).

[49]CMS Form 2567 for Nursing Home in Vicksburg (June 27, 2002) (G-level violation).

[50]CMS Form 2567 for Nursing Home in Grenada (Apr. 11, 2002) (G-level violation).

[51]CMS Form 2567 for Nursing Home in Grenada (Apr. 11, 2002) (G-level violation).

[52]CMS Form 2567 for Nursing Home in Jackson (June 21, 2001) (G-level and H-level violations).

[53]CMS Form 2567 for Nursing Home in Grenada (Apr. 11, 2002) (L-level violation).

Other violations, while not causing immediate harm, reveal the indifferent attitude sometimes displayed by nursing homes towards residents. One facility was cited for failing to protect the dignity of its residents. In one example, a nurse aide left a room door open while the resident "was standing beside the bed totally nude with the upper posterior area and lower body exposed." The curtain near the bed was only partially pulled and the blinds near the bed were open to the facility patio area.[54]

Another facility failed to keep pests away. Seven different residents informed inspectors that they had "flies, roaches, spiders and mice" in the residents' rooms. In the course of three hours, inspectors observed numerous flies in the facility and a "big roach" crawling in front of a resident's bed.[55]

V. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by the nursing homes in the Second Congressional District has been poor. This report reviewed the OSCAR and complaint databases and a sample of actual state inspection reports. The same conclusion emerges from both analyses: many nursing homes in the Second Congressional District are failing to provide the care that the law requires and that families expect.

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[54]CMS Form 2567 for Nursing Home in Vicksburg (July 13, 2001) (G-level violation).

[55]CMS Form 2567 for Nursing Home in Clarksdale (Sept. 13, 2001) (D-level violation).